

FILED MAR 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHDr. Parks  
State File No. 8352

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>128</u>  |  | PRIMARY REG. DIST. NO. <u>2000</u>   |  | Registrar's No. <u>256</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>Springfield</u>   |  | c. LENGTH OF STAY (in this place)<br><u>Life</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>Springfield</u>   |  | 0396   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>923 N. Grant</u>   |  |  |  | d. STREET ADDRESS (If rural, give location)<br><u>923 N. Grant</u>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |  | a. (First)<br><u>Charles</u>   |  | b. (Middle)<br><u>Walter</u>   |  | c. (Last)<br><u>Wilkerson</u>  |  |
| 4. DATE OF DEATH   |  | (Month) (Day) (Year)<br><u>March 19, 1950</u>  |  |  |  |  |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>   |  | 8. DATE OF BIRTH<br><u>Nov. 17 1874</u>  |  |
| 9. AGE (In years last birthday)<br><u>75</u>   |  | 10. UNDER 1 YEAR<br>Months Days<br><u>75</u>   |  | 11. UNDER 1 YEAR<br>Months Days<br><u>75</u>   |  | 12. UNDER 1 YEAR<br>Hours Min.<br><u>75</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Iron Moulder</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Springfield, Mo.</u>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |  |  |  |  |  |  |
| 13a. FATHER'S NAME<br><u>James Wilkerson</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>Margaret Baughman</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Elizabeth Wilkerson</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Mrs. Elizabeth Wilkerson Spfld, Mo</u>   |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                        |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Branchiogenic Carcinoma,</u><br>ANTECEDENT CAUSES <u>Left Main Bronchus</u><br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Atelectasis Left Lung.</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mo.</u><br><br><u>11-2X</u><br><u>4 mo.</u> |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION<br><u>None</u>  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><u>None</u>  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)  |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><u>None</u>   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>12-29, 1949</u> , to <u>3-19, 1950</u> , that I last saw the deceased alive on <u>3-19, 1950</u> , and that death occurred at <u>10 P.m.</u> , from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 23a. SIGNATURE (Degree or title)<br><u>William J. Darr, M.D.</u>   |  | 23b. ADDRESS<br><u>Springfield, Missouri</u>   |  | 23c. DATE SIGNED<br><u>3-21-50</u>   |  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 24b. DATE<br><u>2/22/50</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>St. Mary</u>  |  | 24d. LOCATION (City, town, or county) (State)<br><u>Springfield, Mo.</u>             |  |
| DATE REC'D BY LOCAL REG<br><u>3-22-50</u>  |  | REGISTRAR'S SIGNATURE<br><u>W.E. Handley</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>H.H. Lohmeyer Springfield, Mo.</u>  |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 7 1950

KS JUN 10 1960

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Walter E. Hamer*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 3808

P. O. Address Springfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.